# Claims Clues

A Publication of the AHCCCS Claims Department June, 2004

## New Legislation Requires AHCCCS to Adjust Fee-for-Service Outpatient Hospital Payments

Pursuant to Senate Bill 1410, the AHCCCS Administration will proportionally decrease hospital-specific fee-for-service outpatient cost-to-charge ratios (CCRs) to account for rate increases effective July 1, 2004 – June 30, 2005 for existing outpatient hospital services that exceed 4.7 per cent.

This limits hospitals to one outpatient hospital rate increase for existing services between July 1, 2004 and June 30, 2005. These updates will be on a hospital-specific basis, and are applicable prior to the implementation of the outpatient hospital capped fee schedule on July 1, 2005.

The effective date of the CCR update will be the same date as the effective date of the rate increase, with no adjusted CCR effective dates prior to July 7, 2004, in order to comply with the 30-day notification requirement in A.R.S. 36-2903.01.

To view the complete language in Senate Bill 1410, visit ALIS Online at www.azleg.state.az.us. ❒

## Letter Clarifies HIPAA Privacy Misconceptions

In April, the health care industry marked the first anniversary of implementation of federal protections for the privacy of individual health information under the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

To mark the occasion, the director of the federal agency charged with enforcing the privacy rule has written a letter to providers clarifying many misconceptions about the rule. The text of the letter from Richard Campanelli, director of the Office of Civil Rights (OCR) in the Department of Health and Human Services can be viewed on the OCR Web site at http://www.hhs.gov/ocr/Healthcare-Provider-letter.pdf.

A wide variety of helpful guidance materials also is available on the OCR Web site at www.hhs.gov/ocr/hipaa/.

Here are some highlights from Campanelli's letter:

- HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes.
- HIPAA does not require providers to eliminate all incidental disclosures. The Privacy Rule recognizes that it is not practicable to eliminate all risk of incidental disclosures.
- HIPAA does not cut off all communications between providers and the families and friends of patients. Doctors and other providers covered by HIPAA can share needed information with family, friends and anyone else a

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## New Code Approved for Stretcher Van Mileage

Based on an AHCCCS request, the HCPCS National Panel approved a new code for non-emergency transportation stretcher van, mileage.

Effective for dates of service on and after July 1, 2004 stretcher van providers may use the new code T2049 for non-emergency transportation stretcher van mileage.

Currently, stretcher van mileage is reported using S0209 (Non-emergency transportation wheelchair van, mileage, per mile.)

AHCCCS encourages stretcher van providers to use the new code, to report mileage after the July 1 effective date. Stretcher van provider mileage must be reported using T2049 beginning with dates of service January 1, 2005.

The 2004 AHCCCS fee-for-service rate for T2049 will be identical to the S0209 rate of $1.35 per mile. ❒

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patient identifies as involved in his or her care as long as the patient does not object.

- HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else.
- HIPAA does not prevent child abuse reporting.
- HIPAA is not anti-electronic. Doctors can continue to use E-mail, the telephone, or fax machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy. ❐

# Dentists Must Enter ID in Correct Field on ADA Form

Dentists should ensure that their AHCCCS provider ID is entered in the appropriate field on the ADA 2002 claim form when submitting fee-for-service claims to the AHCCCS Administration.

The provider ID of the *treating* dentist must be entered in Field 54 of the claim form. The ID number of the *billing* dentist or dental entity should be entered in Field 49. ❐

# Communications Center Changes Hours

Effective June 1, the AHCCCS Communications Center is open from 7:00 a.m. - 9:00 p.m. Monday through Friday and 8:00 a.m. - 6:00 p.m. Saturday and Sunday.

Newborns born between 9:00 p.m. and midnight Monday through Friday or 6:00 p.m. and midnight Saturday and Sunday should be reported to the Newborn Unit via fax. The fax number is (602) 252-2136. The fax date will be considered the date of notification.

Providers who need to verify eligibility and enrollment are encouraged to use one of the following verification processes rather than calling the Communications Center.

- Internet

The AHCCCS Online Web application allows providers to verify eligibility and enrollment using the Internet.

To create an account and begin using the application, go to the AHCCCS home page at www.ahcccs.state.az.us. Click on Links for Plans and Providers. A link on the Quick Links for Health Plans and Providers page allows providers to create an account.

- Medical Electronic Verification System (MEVS)

MEVS uses "swipe card" technology to verify recipient eligibility and enrollment. For information on MEVS, contact Envoy at (615) 231-4989

- Eligibility Verification System (EVS)

EVS, also known as Medifax, allows providers to use a PC or terminal to verify eligibility and enrollment. For information on EVS, contact the Potomac Group at 1-800-444-4336.

- Interactive Voice Response (IVR)

IVR allows unlimited verifications using a touch-tone telephone. Providers may call IVR at:

Phoenix: (602) 417-7200

All others: 1-800-331-5090 ❐

# First 3 Digits of UB-92 Dx Code Must Match Authorization

Hospital billers do not need to request a change in the diagnosis code on an authorization for a fee-for-service hospital stay unless one of the first three digits must be changed.

If any of the first three digits of the authorized diagnosis code changes, the provider must contact the AHCCCS Prior Authorization Unit to request a change in the authorization.

The primary or admitting diagnosis does not need to match the authorization as long as any one of the other covered diagnosis codes on the claim matches what has been authorized. ❐

# Admit, Discharge Hours Not Required on Outpatient Claims

UB-92 billers are no longer required to provide the admission and discharge hours on fee-for-service outpatient claims submitted to the AHCCCS Administration.

The admission hour (Field 18) and the discharge hour (Field 21) are required for all inpatient claims.

The on-line version of the *AHCCCS Fee-for-Service Provider Manual* will be updated to include this change. Holders of paper manuals should note this change in their manuals. ❐